While agreeing that the indirect teaching adjustment should be lowered, other individuals argue that the reductions in Medicare's payments should be returned to hospitals in general rather than removed from the PPS system as budget savings. They hold this view because the indirect teaching adjustment was originally financed by lowering payments to all other hospitals rather than by increasing outlays.

The Congress might want to consider recalculating and lowering the basic rates (see ENT-01) and reducing indirect teaching payments simultaneously. In this case, the payment reductions resulting from this last option might either be used to lower Medicare outlays as described above, or they could be returned to all hospitals by allowing PPS rates to be somewhat higher than would result from implementing ENT-01 alone.

ENT-03 REDUCE REIMBURSEMENTS FOR CAPITAL EXPENDITURES UNDER MEDICARE

Savings from CBO Baseline	Annual Savings (millions of dollars) 1988	1989	1990	1991	1992	Cumulative Five-Year Savings
Move Immediately to a Prospective Reimbursement System						
Outlays	120	180	220	250	310	1,080
Move Immediately to a Prospective Reimbursement System and Redefine Capital Expenses						
Outlays	290	330	340	390	450	1,800
Move Slowly to a Prospective Reimbursement System and Redefine Capital Expenses						
Outlays	10	45	120	220	360	760

Although the Social Security Amendments of 1983 set up a prospective payment system (PPS) to reimburse hospitals for operating costs associated with treating Medicare beneficiaries in various diagnosis-related groups (DRGs), they did not change the retrospective, cost-based method of reimbursing capital-related expenses such as interest, rent, and depreciation. Under the Omnibus Reconciliation Act of 1986, cost-based reimbursements will be reduced by 3.5 percent in fiscal year 1987, 7.0 percent in 1988, and 10 percent in 1989. Reimbursements for capital expenses account for about 9 percent of Medicare payments to hospitals--roughly $4 billion in fiscal year 1987.

All three of the approaches discussed here would lead to prospective payment for capital-related expenses. The first two would do so immediately, while the third would partially retain cost-based reimbursement during a five-year transition to a fully prospective system. In addition, two of the approaches would redefine the capital expenses that would be eligible for reimbursement under the prospective system. Under all three approaches, the payments would be reduced by an additional 7 percent in 1988 and 10 percent in 1989 to parallel the cuts enacted in 1986.

Move Immediately to a Prospective Reimbursement System. The current cost-based method of reimbursement for capital-related expenses could be replaced immediately by a prospective system under which capital expenses would be reimbursed by increasing the DRG rates to reflect capital costs. If payments for capital were set to their level in 1987 on a per-case basis, Medicare outlays would be reduced by $1.1 billion during the 1988-1992 period. These savings would accrue because the DRG payments are projected to grow more slowly than actual capital costs.

Reimbursing capital expenses by increasing the current DRG rates would have several advantages. First, hospitals would have incentives to reduce their capital costs as well as operating costs--for example, by seeking to delay projects when interest rates were high, whereas now that is not advantageous because all interest costs are reimbursed. In addition, this approach would avoid the current incentive to substitute capital for labor--the incentive that comes from combining prospective reimbursement for operating costs with cost reimbursement for capital expenses--even when that substitution would raise the hospital's total costs. Finally, prospective payments by Medicare would make federal outlays more predictable and controllable--for example, they could be controlled even if a hospital building boom occurred in the coming years.

The major drawback to this approach is that the capital expenditures of individual hospitals tend to be large and to occur infrequently. As a result, some hospitals have capital expenses that are much higher than average in some years and much lower in other years. In other words, an add-on based on the average level of capital costs per case in a base year would generally not match any particular hospital's current expenses.

A way to avoid large windfall gains and losses for some hospitals would be to have a transition period during which part of the prospective payment would be based on the increase or add-on described above and part would be based on the particular hospital's capital costs per case in the base year. This modification--which is similar to the transition method used under the PPS system for operating costs--would still move to a prospective system immediately and would not affect the total savings. The distribution of payments among hospitals during the transition period would differ, however. Hospitals that have recently undertaken large capital obligations would gain, relative to using only a national add-on, while hospitals that currently have below-average capital expenses but need to modernize in the near future would lose.

Move Immediately to a Prospective Reimbursement System and Redefine Capital Expenses. In addition to paying for capital prospectively, as in the

previous option, the definition of capital expenses used to calculate the add-on could be changed in two ways. First, Medicare could exclude the proportion of capital costs related to return-on-equity (ROE), which is currently an allowable cost only for proprietary hospitals. Under the provisions of the Consolidated Budget Reduction Act of 1986, payments for ROE will be reduced by 25 percent in fiscal year 1987, 50 percent in 1988, and 75 percent in 1989. Thereafter, Medicare will not reimburse for ROE. Under this option, the Congress would end payments for ROE in 1987.

Proponents argue that the federal government ought to reimburse all hospitals in the same way--whether they are voluntary or proprietary. Moreover, because proprietary hospitals receive only about 10 percent of Medicare's payments, they point out that including ROE in the base for calculating the average capital cost per case would spread these payments across all hospitals, effectively generating windfall gains for the voluntary ones. But other analysts contend exactly the opposite--that ROE is a legitimate cost of doing business and either should continue to be reimbursed based on actual costs or should be paid prospectively under a separate add-on that would apply only to proprietary hospitals.

A second definitional change would reduce the amount of interest expenses used to calculate the add-on by the amount of interest hospitals earn on funded depreciation. Advocates of this offset point out that hospitals have invested their funded depreciation to generate income rather than using it to reduce the level of their outstanding debt. Moreover, they argue that the federal government should not reward hospitals for the resulting increase in their interest expenses. Opponents contend, on the other hand, that the prospective payments for operating costs have not kept up with inflation and that further cuts in federal payments would add to the financial stress some hospitals are experiencing from the PPS.

This option would lower Medicare's outlays by $1.8 billion during the 1988-1992 period. These savings would accrue both because the redefinition would lower the 1987 base amount of capital expenses, and because under the prospective system for capital--which shares the advantages and disadvantages discussed in the previous option--payments are projected to grow more slowly than actual capital costs.

Move Slowly to a Prospective Reimbursement System and Redefine Capital Expenses. Another approach would be to move gradually from the current cost-based system to a prospective one in which capital expenses were redefined. For example, if during a five-year transition period, 95 percent, 80 percent, 60 percent, 40 percent, and 20 percent, respectively, of the

reimbursement were based on capital costs as now defined, with the remainder based on the prospective system described in the second option, cumulative savings for fiscal years 1988 through 1992 would be $760 million.

Advocates of this approach argue that continuing partial cost-based reimbursement during a transition period would lessen financial stress for two large groups of hospitals--those with current high capital costs and those planning large capital investments during the transition period. It also would reduce windfall gains for many others whose actual costs would be below Medicare's payments under either of the first two options. Opponents counter that this approach would substantially reduce budgetary savings compared with immediate implementation of a prospective system and that the positive incentives of paying prospectively would be delayed.

ENT-04 REDUCE TOTAL MEDICARE DIRECT MEDICAL EDUCATION PAYMENTS

Savings from CBO Baseline	Annual Savings (millions of dollars) 1988	1989	1990	1991	1992	Cumulative Five-Year Savings
Outlays	150	160	170	170	180	830

Medicare's prospective payment system does not include payments to hospitals for their direct costs of graduate medical education (GME)--that is, residents' and teachers' salaries, administrative costs, classroom expenses, and the associated hospital overhead costs. Instead, these payments are made separately, but also prospectively, based on Medicare's share of the hospital's historical cost per resident. Medicare's GME payments, which are received by about one in six hospitals, represent approximately 2 percent of Medicare's payments for inpatient care, but cover nearly one-third of hospitals' total GME costs..

Several arguments support reducing Medicare's payments for GME. Many observers argue that such subsidies are unwarranted since the United States is facing a projected aggregate surplus of physicians. Moreover, since physicians earn much higher incomes as a result of their GME, they might reasonably contribute more to these costs themselves.

If the Congress were to reduce Medicare's total GME payments by 15 percent, the five-year savings would be about $830 million. (This option would not change training programs for nursing and allied health professions.) This reduction could be accomplished in several ways: reduce the per-resident payment for every hospital by 15 percent; cap each hospital's per-resident payment at the median; or eliminate per-resident payments to hospitals for graduates of foreign medical schools (FMGs).

Among those groups who believe Medicare's GME payments should be reduced, advocates of a uniform 15 percent reduction in per-resident payments support it mainly on grounds of fairness. Advocates of a cap suggest that only constraining payments to hospitals with historically high per-resident costs would generally penalize the most inefficient hospitals. Advocates of eliminating payments to FMGs favor discouraging their employment because of concerns about their quality as well as their contribution to projected surpluses of physicians.

Reducing Medicare's GME payments could have several drawbacks, however. Many hospitals have built their training programs based on expectations of Medicare's reimbursements for GME. Decreasing or eliminating Medicare's GME payments could force some programs to reduce the resources they commit to training, or even to close. This response could, in turn, reduce access to health-care services in some communities.

ENT-05 ADOPT A FEE SCHEDULE FOR REIMBURSING PHYSICIANS UNDER MEDICARE

Savings from CBO Baseline	Annual Savings (millions of dollars) 1988	1989	1990	1991	1992	Cumulative Five-Year Savings
Fee Schedule with Rates Updated Annually by the MEI						
Outlays	90	340	500	660	820	2,410
Fee Schedule with Spending Cap Set by the MEI						
Outlays	560	2,140	3,680	5,410	7,380	19,170
Fee Schedule with Spending Cap Set by Growth in GNP						
Outlays	200	770	1,250	1,880	2,670	6,770

Medicare currently reimburses physicians under the Supplementary Medical Insurance (SMI) program for "reasonable" charges for all covered services. A reasonable charge for a given service is the lowest of the physician's actual charge, the physician's customary charge for that service, or the prevailing charge for that service in the local community. This practice is known as the customary, prevailing, and reasonable (CPR) system.

Because of the automatic and inflationary link between physicians' actual charges and Medicare's payment rates in the next year, the CPR system has been criticized for contributing unnecessarily to cost increases. To weaken this link, since 1973, the allowed rate of increase in prevailing fees has been limited to the rate of increase in an economywide index of office expenses and earnings--the Medicare Economic Index (MEI). Because only about half of all physicians' charges are at the ceiling set by MEI-adjusted prevailing fees, however, the rate of increase in payment rates has exceeded increases in the MEI.

Rates Updated by the MEI. One alternative to the CPR system would be to implement a Medicare fee schedule for physicians' and related services--with adjustment for local differences in costs. A fee schedule could perhaps be put in place by January 1, 1988. The fee schedule that would be

effective during 1988 could be set at the average amounts allowed for each service during 1987, with increases in payment rates for 1988 and each year thereafter determined by the rate of increase in the MEI. Savings under this option would be $90 million for fiscal year 1988. Savings would total $2.4 billion over the 1988-1992 period, reducing net SMI outlays by about 1.4 percent.

A fee schedule based on average allowed amounts would incorporate elements of the current fee structure that many people believe need to be corrected. For example, current amounts may include excessive payments for certain procedures that are either ineffective or far less costly to perform now than when they were first introduced. The rate structure could be modified incrementally after it has been put in place, or changes in physician payment methods could be delayed for a year or two until a more appropriate fee structure was developed. (The Health Care Financing Administration has awarded a contract to develop a relative value scale that could serve as the basis for a fee schedule; completion is scheduled for mid-1988.) Control of total costs in a fee-for-service payment system probably requires constraints on the volume the of services as well as on fees, however. Without volume controls, some physicians might respond to constraints on fees by providing additional reimbursable--but unnecessary or only marginally useful--services.

Cap Set by the MEI. Other countries have successfully contained increases in volume under fee-for-service systems by using a combination of two mechanisms: volume-related adjustments in payment rates to cap total spending for physicians' services, together with a systematic monitoring of the practice profiles of physicians to prevent individual ones from making above-average increases in their billings at the expense of other physicians. If increases in the average approved charges per enrollee were limited by increases in the MEI--so that payment rates would be reduced to offset increases in the average volume per enrollee--savings under the fee schedule discussed above would increase to $560 million for 1988 and would total $19.2 billion over the five-year period. Some increases in the average volume of services per enrollee might be desirable, however, to account for aging of the Medicare population and medical advances.

Cap Set by Growth in GNP. Average charges per enrollee could be permitted to increase by the growth in physicians' practice costs plus an appropriate allowance for aging and technology, before triggering a downward adjustment in payment rates. The appropriate allowances for these factors could be difficult to determine, however. To do so would be especially difficult for medical advances, which might either increase or reduce the variety and costs of services that could benefit enrollees.

Medicare's and patients' costs. In fact, coinsurance and balance-billing amounts for which patients are currently liable under Part B of Medicare would be eliminated on inpatient services provided by RAPs. Consequently, out-of-pocket costs for patients would drop by a much higher percentage than Medicare's costs.

Either RAPs or hospitals, however, would be worse off under this option. Total payments to RAPs for services to Medicare inpatients would fall, unless hospitals accepted the loss by paying RAPs more, on average, than the amount by which DRG rates were increased. The allocation of this reduction in receipts between RAPs and hospitals would vary by locality, depending on the extent of competition for the services of RAPs. The reduction in Medicare receipts that would occur under this option might adversely affect access for Medicare enrollees in some isolated areas. But this effect would not be widespread because RAPs are among the most highly paid physician specialties, and because most hospitals have fared well under the prospective payment system.

ENT-07 INCREASE MEDICARE'S PREMIUM FOR PHYSICIANS' SERVICES

Savings from CBO Baseline	Annual Savings (millions of dollars) 1988	1989	1990	1991	1992	Cumulative Five-Year Savings
Outlays	1,180	2,210	3,080	4,060	5,180	15,710

Medicare's Supplementary Medical Insurance (SMI) program is partially funded by monthly premiums--currently $17.90--paid by enrollees. Between 1972 and 1982, premium receipts covered a declining share of SMI costs--dropping from 50 percent to 25 percent--because premiums were tied to the rate of growth in Social Security benefits, which is based on the Consumer Price Index, rather than on the faster-rising per capita cost of SMI. (The remaining costs are paid from general revenues.)

In 1982, premiums were set through 1985 (later extended through 1988) to cover 25 percent of the average benefits for an aged enrollee. Under current law, beginning in 1989 the premium calculation will again be limited to the rate of growth of Social Security benefits. If, instead, the premium were set so that enrollees would pay 30 percent of benefits beginning January 1, 1988, and for all years thereafter, federal savings would total $1.2 billion in fiscal year 1988 and $15.7 billion over the five-year period. The estimated premium would be $26.10 on January 1, 1988, instead of the scheduled $21.70. Net outlays for SMI would be reduced by about 9 percent over the five-year period.

Under this option, the increase in payments would be shared by all enrollees, in contrast to proposals--such as increasing copayments--that would affect only the users of medical services, who may be financially pressed during their period of illness. Also, this option would not affect the poorest enrollees because they are likely to be eligible for Medicaid, which usually pays the SMI premium on their behalf. For those not eligible for Medicaid, the higher premium would be about 5 percent of the average monthly Social Security benefit in 1988, slightly more of a burden than in 1967--the first full year for Medicare--when the premium was 3.6 percent of the average Social Security benefit.

Low-income enrollees who are not eligible for Medicaid, however, could find the increased premium burdensome. A few might drop SMI coverage and either do without care or turn to sources of free or reduced-cost care, which could increase demands on local governments. In addition, the costs for states would increase for Medicaid-eligible Medicare enrollees because states would pay part of the higher premium costs for those enrollees.

ENT-08 USE THE TAX SYSTEM TO IMPOSE A SUPPLEMENTARY INCOME-RELATED PREMIUM FOR PHYSICIANS' SERVICES

	Annual Added Revenues (billions of dollars)					Cumulative Five-Year Savings
	1988	1989	1990	1991	1992	
Addition to CBO Baseline	0.6	2.0	2.2	2.4	2.6	9.8

Part B of Medicare offers Supplementary Medical Insurance (SMI), which covers a portion of enrollees' physician and other nonhospital charges. Participation is voluntary, and enrollees currently pay a monthly premium of $17.90. The premium is adjusted annually (through 1988) to cover 25 percent of the average benefits received by elderly enrollees. The balance of costs, more than $25 billion for 1988, is paid from general revenues.

An alternative to increasing the share of costs financed by the premium would be to impose a supplementary income-related premium that would be paid by all SMI enrollees. To avoid having to set up a new bureaucracy to collect these premiums from enrollees, this option could be most conveniently introduced through the income tax system. This approach would exempt from the tax those individuals who chose not to enroll in the SMI program.

A 1 percent tax, for example, could be imposed on enrollees' taxable income. A ceiling on added tax liability for each tax filing unit (usually an elderly individual or couple) could be set by the number of SMI enrollees in the unit times the average value of subsidized SMI benefits per enrollee. In this way, no unit would pay more than the full actuarial value of its benefits. If an SMI tax of 1 percent were imposed on taxable income for all units with at least one SMI enrollee during the tax year (prorated for part-year enrollment), revenues earmarked for the SMI trust fund would be increased by $0.6 billion in 1988, and by $9.8 billion over the 1988-1992 period. Five-year revenues would equal about 6 percent of SMI net outlays.

In contrast to the premium discussed in ENT-07, this approach would fall less heavily on low-income enrollees and more heavily on those with high incomes. The poorest enrollees--those with no taxable income--would

67-341 O - 87 - 3

not be affected, whether or not they were eligible for Medicaid benefits. The amount paid would vary directly with the amount of taxable income. As a result, individuals with taxable income below $5,280 a year would pay less under this approach, while those with taxable income above $5,280 would pay more than if premiums were increased to cover 30 percent of costs. The effect on low- and moderate-income enrollees could be reduced still further by using personal income tax rates--as in ENT-09--rather than the proportional tax used in this option.

Some people might consider this tax inequitable because the amount of tax paid by each tax unit would not vary with the number of SMI enrollees in a unit, except for a small number of high-income tax units affected by the ceiling. In addition, some might question whether it was fair to require those with higher incomes to pay a relatively greater share of SMI costs when such people are typically less costly to the Medicare program because of their better health.

ENT-09 TAX A PORTION OF MEDICARE BENEFITS

Addition to CBO Baseline	Annual Added Revenues (billions of dollars) 1988	1989	1990	1991	1992	Cumulative Five-Year Addition
With Income Threshold	0.7	2.5	3.0	3.6	4.2	14.0
Without Income Threshold	1.4	5.0	5.6	6.4	7.2	25.6

Eligibility for Hospital Insurance (HI) benefits is based on working-year tax contributions, half of which are paid by employees from after-tax income and half by employers from pre-tax income. Eligibility for Supplementary Medical Insurance (SMI) depends on payment of a premium, which currently covers about 25 percent of SMI benefits. Hence, effective January 1, 1988, 50 percent of the insurance value of HI benefits and 75 percent of the insurance value of SMI benefits might be treated as taxable income for enrollees. (The resulting tax proceeds could be returned to the Medicare trust funds.) This proposal is analogous to taxing part of Social Security benefits, which is already part of the law for beneficiaries for whom modified adjusted gross income plus half of Social Security benefits exceeds $25,000 (for individuals) or $32,000 (for couples) (see REV-18).

If the current income thresholds for the tax on Social Security benefits were also used to limit the application of the tax on Medicare benefits--with the portion of Medicare benefits described above added to modified adjusted gross income plus half of Social Security benefits to compare with the threshold--then taxing both HI and SMI benefits would yield additional revenues of $0.7 billion in 1988 and $14 billion over the 1988-1992 period. If no income thresholds were used to limit the application of the Medicare tax, additional revenues would be $1.4 billion in 1988 and $25.6 billion over the five-year period.

A tax on HI benefits would strengthen the HI trust fund. A tax on SMI benefits would shift some SMI costs from the general taxpayer to enrollees, without increasing costs for low-income enrollees and therefore not threatening their access to care. Moreover, if income thresholds were used, even middle-income enrollees would be protected from additional liability

under this option. In contrast to ENT-08, people enrolled in the SMI program would never pay the full insurance value of their benefits under this option, since the maximum personal income tax rate to be applied to the subsidy value of benefits would be 33 percent under current law. Further, since this option would use the mechanism already in place for taxing Social Security benefits, it would present no additional administrative difficulty.

Unlike the tax on Social Security benefits, though, this tax would be imposed on the insurance value of in-kind benefits rather than on dollar benefits actually received--a modification of current tax policy. (If the tax were imposed on actual benefits received, however, the Medicare tax would be directly related to enrollees' health-care costs, reducing the insurance protection Medicare is intended to provide.) In addition, some people might object to this option because enrollees could not alter their tax liability by choosing a different package of benefits, except by dropping SMI or all Medicare coverage. Further, because of their better health, people with higher incomes are typically less costly to the Medicare program. Thus, requiring them to pay a greater share of the costs might be viewed as inequitable. Finally, the additional tax liability could be substantial for some enrollees--nearly $500 in 1988 for those in the 28 percent tax bracket, although most Medicare enrollees would be in a lower tax bracket or unaffected by the proposal.

ENT-10 INCREASE MEDICARE'S DEDUCTIBLE FOR PHYSICIAN SERVICES

Savings from CBO Baseline	Annual Savings (millions of dollars) 1988	1989	1990	1991	1992	Cumulative Five-Year Savings
Outlays	1,000	1,670	1,930	2,120	2,320	9,040

Appreciable federal savings in Medicare's Supplementary Medical Insurance (SMI) program could be realized by increasing the deductible--that is, the amount that enrollees must pay for services each year before the government shares responsibility. The deductible is now $75 a year. This deductible has been increased only twice since Medicare began in 1966, when it was set at $50. Hence, the deductible has fallen relative to average per capita benefits from 70 percent in 1967 to less than 8 percent for 1987. Increasing the SMI deductible to $200 on January 1, 1988, and indexing it thereafter to the rate of growth in the Consumer Price Index would save $1 billion in fiscal year 1988. Savings would total $9 billion over the five-year period from 1988 through 1992, reducing SMI outlays by about 5 percent.

Such an increase would spread the burden of reduced federal outlays among most enrollees, raising their out-of-pocket costs by no more than $125 each in 1988 (which would be partially offset by reduced premium costs of $1.10 a month). Since a larger proportion of enrollees would not exceed the deductible (currently about 30 percent do not), it would both increase the number of enrollees with strong incentives for prudent consumption of medical care and reduce administrative costs to process claims.

On the other hand, even relatively small increases in out-of-pocket costs could prove burdensome to low-income enrollees who do not receive Medicaid, which pays deductible amounts for dual Medicaid-Medicare beneficiaries. That added expense might, in turn, discourage some people from seeking needed care.

ENT-11 CAP EACH ENROLLEE'S COPAYMENT LIABILITY UNDER MEDICARE AND IMPOSE A TAX ON "MEDIGAP" POLICIES

Savings from CBO Baseline	Annual Savings (millions of dollars) 1988	1989	1990	1991	1992	Cumulative Five-Year Savings
Outlays	860	2,700	3,760	4,140	4,350	15,810

As a result of Medicare's cost-sharing requirements and limitations of coverage, enrollees who require many services during the year can incur substantial costs. The potential for high out-of-pocket costs--that is, cost-sharing other than premiums--induces about 70 percent of aged Medicare enrollees to purchase supplementary private insurance ("medigap" policies) to cover those costs. For those with supplementary coverage, use of services is higher than it would otherwise be because cost-sharing is eliminated. This effect increases not only medigap benefit payments, but also raises Medicare's costs. For those who lack supplementary coverage, out-of-pocket costs may sometimes be prohibitive, with the result that some enrollees may be unable to obtain needed health-care services.

Medicare could cap each enrollee's annual copayment liability and finance this new benefit by imposing a tax on benefits paid by medigap policies (which would probably cause insurers to raise medigap premiums). If each enrollee's liability for copayments under Medicare were capped at $2,000 in 1988, with the cap increased each year thereafter by the Consumer Price Index, Medicare costs would increase by $1.7 billion in 1988. If taxes equal to 80 percent of benefits paid by medigap policies were collected from medigap insurers, the revenues collected would total $2.6 billion in 1988. Net federal savings in fiscal year 1988 would be $0.9 billion. Cumulative savings over the five-year projection period would be $15.8 billion, reducing net outlays for Medicare by about 3 percent. (The medigap tax revenues are treated as negative outlays here.)

The copayment cap would protect most enrollees against catastrophic out-of-pocket costs for acute health-care needs--protection that those without supplementary coverage do not have at present. A medigap tax of 80 percent would be just sufficient to recover the extra federal costs that arise because medigap policyholders use more Medicare-covered services than

those without supplementary coverage. Federal savings from the medigap tax would stem either from tax receipts on policies that enrollees continued to purchase despite their higher cost, or from lower use of health-care services by those who would drop medigap coverage in response to improved Medicare coverage and higher medigap premiums.

Some private insurers might object to this approach, though, because Medicare enrollees would probably purchase fewer medigap policies. In addition, copayment costs could still be prohibitive for some low-income enrollees because the cap would not be income-related (a modification that would be difficult to administer).

Except for the cap, this proposal would leave the current structure of copayments unchanged, although many people think that it is inappropriately designed. The proposal could, however, easily be modified to include any new copayment requirements as well as the copayment cap. For example, cost-sharing could be introduced to curtail overuse of services where patients can exercise considerable discretion (such as home health services). At the same time, cost-sharing could be eliminated for services--such as extended hospital stays--where use is largely beyond the patient's control.

A related proposal to set limits on copayments under Medicare was recently introduced by the Secretary of the Department of Health and Human Services. Under that plan, the new Medicare benefits would be financed by an additional premium paid by all enrollees.

ENT-12 LIMIT FEDERAL PAYMENTS FOR LONG-TERM CARE

Savings from CBO Baseline	Annual Savings (millions of dollars) 1988	1989	1990	1991	1992	Cumulative Five-Year Savings
Reduce Federal Medicaid Matching Rate						
Budget Authority	790	870	950	1,040	1,130	4,780
Outlays	790	870	950	1,040	1,130	4,780
Limit Federal Medicaid Increases to the Medical CPI Rate						
Budget Authority	860	930	1,020	1,100	1,190	5,100
Outlays	860	930	1,020	1,100	1,190	5,100
Establish a Comprehensive Block Grant						
Budget Authority	1,350	2,900	4,400	6,000	7,650	22,350
Outlays	1,350	2,900	4,400	6,000	7,650	22,350

In the last several years, federal spending for long-term care has grown rapidly, often exceeding the growth in outlays for several other types of health care. For example, between 1980 and 1985, federal Medicaid payments for hospital care grew by an average annual rate of 8 percent, while payments for nursing home and home health services grew at an 11 percent rate. Medicaid spending for nursing home care, which made up 45 percent of Medicaid's outlays in 1985, constitutes the bulk of federal costs for long-term care.

Growth in federal outlays for long-term care (LTC) could be controlled in several ways, including: (1) retaining the open-ended funding, but lowering the average federal matching rate for Medicaid LTC services--by 3 percentage points, for example; (2) limiting the increase in federal Medicaid payments for LTC to each state to the inflation rate for medical services; or (3) combining all payments to states for LTC services into a block grant that would remain constant in nominal terms over the next five years. The first two options would each save about $5 billion in federal outlays over the 1988-1992 period, while the block grant would save $22 billion over the same time period.